MEDICAL RECORD	Request for Administration of Anesthesia and for Performance of Operations and Other Procedures

Title of Operation or Procedure:

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be:
(Description of Operation or Procedure in Layman's Language):_____

_____

_____

_____

which is to be performed by or under the direction of Dr. _____

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the Warren Grant Magnuson Clinical Center, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the Warren Grant Magnuson Clinical Center. I have been informed of, and understand, the options for, and risks and benefits associated with, anesthesia.

4. Exceptions to surgery or anesthesia, if any, are (If "none," so state):_____

_____

5. I request the disposal by authorities of the Warren Grant Magnuson Clinical Center of any tissues or parts which it may be necessary to remove.

6. I understand that photographs or movies may be taken of this operation, and that they may be viewed by various individuals, including those undergoing training at this or other facilities. I also understand this operation may be observed by authorized individuals. I consent to the taking of such pictures and observation of the operation by authorized individuals, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

1. Counseling Physician/Dentist: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

Signature of Counseling Physician/Dentist_____ Date_____

2. Patient: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

Signature of Patient_____ Date_____

3. Sponsor of Guardian (When patient is a minor or unable to give consent): I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, and hereby request such procedure(s) be performed.

Signature of Sponsor/Legal Guardian_____ Date_____

4. Witness:

Signature of Witness_____ Date_____

(Excluding Members of the Operating Team

Patient Identification	Request for Administration of Anesthesia and for Performance of Operations and Other Procedures NIH-2626 (10-00) P.A. 09-25-0099 File in Section 4: Authorization